HMIS EXIT Data Collection Form for Solano County Projects

General Instructions

This is the exit form for ALL projects in Solano County except for PATH, RHY, and VA programs. This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household. If a household presents as two minor youth, one of the youth should be designated as the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response. Please note that current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary. If the data dictionary does not answer your question, please reach out to solanoHMIS@homebaseccc.org for assistance.

CLIENT NAME:

DATE ADMINISTERED:

EXIT DESTINATION

PROJECT EXIT DATE

The Project Exit Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day			Year			

REASON FOR LEAVING

☐	Completed program	☐	Disagreement with rules or persons
☐	Left for housing opportunity before completing program	☐	Criminal activity or violence
☐	Reached maximum time allowed	☐	Death
☐	Needs could not be met	☐	Unknown or disappeared
☐	Non-compliance with program	☐	*If* **OTHER**, *specify:* _____
☐	Non-payment of rent		

DESTINATION

Which of the following most closely matches where the client will be staying right after leaving this project?

☐	Place not meant for habitation	☐	Moved from one HOPWA funded project to HOPWA PH
☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Moved from one HOPWA funded projected to HOPWA TH
☐	Safe Haven	☐	Rental by client, with GPD TIP housing subsidy
☐	Foster care or foster care group home	☐	Rental by client, with VASH housing subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Permanent housing (other than RRH) for formerly homeless persons
☐	Jail, prison or juvenile detention facility	☐	Rental by client, with RRH or equivalent subsidy
☐	Long-term care facility or nursing home	☐	Rental by client, with HCV voucher (tenant or project based)
☐	Psychiatric hospital or other psychiatric facility	☐	Rental by client in a public housing unit
☐	Substance abuse treatment facility or detox center	☐	Rental by client, no ongoing housing subsidy
☐	Residential project or halfway house with no homeless criteria	☐	Rental by client, with other ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Owned by client, with ongoing housing subsidy
☐	Transitional housing for homeless persons (including homeless youth)	☐	Owned by client, no ongoing housing subsidy
☐	Host Home (non-crisis)	☐	No exit interview completed
☐	Staying or living with friends, temporary tenure	☐	*If* **OTHER**, *specify:* _____
☐	Staying or living with family, temporary tenure	☐	Deceased
☐	Staying or living with family, permanent tenure	☐	Client doesn't know
☐	Staying or living with friends, permanent tenure	☐	Client refused

EXIT DESTINATION (CONTINUED)

NOTES

_____

_____

_____

_____

_____

EXIT LOCATION

Where will the client live after exiting? Select the location from the list below.

☐	Benicia	☐	Other area in Solano County
☐	Birds Landing	☐	Alameda County
☐	Dixon	☐	Contra Costa County
☐	Fairfield	☐	Napa County
☐	Green Valley	☐	Sacramento County
☐	Rio Visa	☐	San Francisco County
☐	Suisun City	☐	Yolo County
☐	Vacaville	☐	Other area in California (non-Solano)
☐	Vallejo	☐	Other area outside of California

DISABILITIES

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond "yes" to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

SUBSTANCE ABUSE

☐	Yes: Alcohol abuse **only**	☐	No
☐	Yes: Drug abuse **only**	☐	Client doesn't know
☐	Yes: Alcohol **and** drug abuse	☐	Client refused

If YES for <u>alcohol abuse</u>, <u>drug abuse</u>, or <u>both alcohol and drug abuse</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

CHRONIC HEALTH CONDITION

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>chronic health condition</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

DEVELOPMENTAL

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>developmental disability</u>, *is the disability expected to substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				

Month Day Year

NOTE ON DISABILITY

_____

_____

_____

_____

DISABILITIES (CONTINUED)

HIV/AIDS

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>HIV/AIDS</u>, *is the disability expected to substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

_____

_____

MENTAL HEALTH PROBLEM

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>mental health problem</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES,** *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

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_____

PHYSICAL

☐	Yes	☐	No
☐	No	☐	Client doesn't know

If YES for <u>physical disability</u>, *is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

IF **YES**, *DISABILITY START DATE*

		/			/				
Month			Day			Year			

NOTE ON DISABILITY

_____

_____

_____

_____

DISABLING CONDITION

A disabling condition is any of the above-indicated disabilities or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long–continued and indefinite duration and substantially impair ability to live independently. ***Does the client currently have a disabling***

☐	Yes
☐	No
☐	Client doesn't know
☐	Client refused

INCOME

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household should be recorded under the Head of Household's information. If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each income source.*

Source of income	Receiving income from source?		If YES, date client began receiving income	If YES, monthly amount from source (round to nearest dollar)
Alimony or other spousal support	Yes	☐		$. 0 0
	No	☐		
Child support	Yes	☐		$. 0 0
	No	☐		
Earned income (*i.e.*, employment income)	Yes	☐		$. 0 0
	No	☐		
General Assistance (GA)	Yes	☐		$. 0 0
	No	☐		
Pension or retirement income from a former job	Yes	☐		$. 0 0
	No	☐		
Private Disability Insurance	Yes	☐		$. 0 0
	No	☐		
Retirement Income from Social Security	Yes	☐		$. 0 0
	No	☐		
Social Security Disability Insurance (SSDI)	Yes	☐		$. 0 0
	No	☐		
Supplemental Security Income (SSI)	Yes	☐		$. 0 0
	No	☐		
Temporary Assistance for Needy Families (TANF)	Yes	☐		$. 0 0
	No	☐		
Unemployment Insurance	Yes	☐		$. 0 0
	No	☐		
VA Non-Service-Connected Disability Pension	Yes	☐		$. 0 0
	No	☐		
VA Service-Connected Disability Compensation	Yes	☐		$. 0 0
	No	☐		
Worker's Compensation	Yes	☐		$. 0 0
	No	☐		
Other source (specify): _____	Yes	☐		$. 0 0
	No	☐		
Total monthly income from all sources				$. 0 0

What is the client's income as a percentage of Area Median Income (AMI)?

☐	< 30%	☐	30–50%	☐	> 50%

Does the client have a connection with SSI/SSDI Outreach, Access, and Recovery (SOAR)?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

NON-CASH BENEFITS

Only record regular, recurrent sources that are current (i.e. not terminated). Non-cash benefits received for a minor member of the household should be recorded under the Head of Household's information. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any non-cash benefits from any source?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each non-cash benefit source.*

Source of Non-Cash Benefit	Receiving source?		If YES, date client began receiving source	If YES, monthly amount from source (round to nearest dollar)
Supplemental Nutrition Assistance Program, (*i.e.* CalFresh or Food Stamps)	Yes	☐		$. 0 0
	No	☐		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	☐		$. 0 0
	No	☐		
TANF Child Care services	Yes	☐		$. 0 0
	No	☐		
TANF Transportation Services	Yes	☐		$. 0 0
	No	☐		
Other TANF-Funded Services	Yes	☐		$. 0 0
	No	☐		
Other: _____	Yes	☐		$. 0 0
	No	☐		

HEALTH INSURANCE

Only record regular, recurrent sources that are current (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

Is the client <u>currently</u> covered by health insurance?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *answer 'Yes' or 'No' for each health insurance source.*

Source of Health Insurance	Receiving health insurance source?		If YES, date client began receiving source	For HOPWA, specify private pay insurance source, if applicable	For HOPWA, specify reason not covered, if applicable
Medicaid (*i.e.* Medi-Cal)	Yes	☐			
	No	☐			
Medicare	Yes	☐			
	No	☐			
State Children's Health Insurance Program (CHIP)	Yes	☐			
	No	☐			
Veteran's Administration (VA) Medical Services	Yes	☐			
	No	☐			
Employer-Provided Health Insurance	Yes	☐			
	No	☐			
Health insurance obtained through COBRA	Yes	☐			
	No	☐			
Private Pay Health Insurance	Yes	☐			
	No	☐			
State Health Insurance for Adults	Yes	☐			
	No	☐			
Indian Health Services Program	Yes	☐			
	No	☐			
Other: _____	Yes	☐			
	No	☐			

EMPLOYMENT

Is the client employed?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *specify the type of employment.*

☐	Full-time	☐	Client doesn't know
☐	Part-time	☐	Client refused
☐	Seasonal/sporadic (including day labor)		

If **NO**, *specify the reason the client is not employed.*

☐	Looking for work	☐	Client doesn't know
☐	Unable to work	☐	Client refused
☐	Not looking for work		

DOMESTIC VIOLENCE

Is the client a domestic violence victim or survivor?

☐	Yes	☐	No	☐	Client doesn't know	☐	Client refused

If **YES**, *when did the experience occur?*

☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
☐	Six months to one year ago (excluding one year exactly)	☐	Client refused

If **YES**, *is the client currently fleeing?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

CONTACT INFORMATION

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____ *County* _____

County _____

What is the data quality of the client's residence or last permanent address?

☐	Full address reported	☐	Client doesn't know
☐	Incomplete or estimated address reported	☐	Client refused

Phone number _____ *Email address* _____

START DATE

		/			/				
Month			Day			Year			

END DATE (if applicable)

		/			/				
Month			Day			Year			

Landlord's Name _____ *Landlord's Address* _____

Landlord's City _____ *Landlord's State* _____ *Landlord's Phone* _____

EMERGENCY CONTACT

Contact's Name _____ *Contact's Address* _____

Contact's City _____ *Contact's State* _____ *Landlord Phone* _____

Second Phone Number _____ *Relationship to Client* _____

START DATE

		/			/				
Month			Day			Year			

END DATE (if applicable)

		/			/				
Month			Day			Year			